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Review of Models of Employment for Nursing Roles which Bridge Practice and Education:

A Report for NHS Education for Scotland

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March 2008

This review paper was commissioned by NHS Education for Scotland. The views and opinions expressed are those of the authors.

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1. Introduction

This review was conducted for NHS Education for Scotland. It investigates the literature pertaining to different models of contractual employment for nurses that 'bridge' practice and education in order to identify the evidence base and current practice in other countries. The specific context for the review was the development of clinical education career pathways in Scotland as part of Modernising Nursing Careers (MNC) initiative.

The objectives were to review the literature on evaluation, and on reported strengths and weakness of different models of employment/deployment of nurses in practice/education roles, to provide a typology of the key characteristics of these different roles – where possible to include job descriptions, types of contractual employment (e.g. fixed term, open ended, joint appointment, sessional etc.); employment status; work location(s) etc. and to highlight examples of such roles in different health systems.

Areas explored in the review included models of employment, career structure, and role content of nurses in these roles. In practice the review of published material highlighted that the literature did not enable all the objectives to be met in detail- in particular there is little published evidence on types of employment contracts etc. This may be because much of the publicly available literature is written from an educational delivery perspective rather than from a workforce/HR perspective. Supplemental information on this issue was obtained from contacts in other countries- notably Canada and New Zealand- to provide relevant background information.

The Practice Education Facilitator (PEF) is one recent NHS Scotland role which aims to support mentors and mentorship in the clinical areas, helping develop and promote those areas as learning environments (NES, 2007). The PEF is just one type of role that bridges between practice and education.

The types and roles of personnel used to bridge the 'practice-education gap', or 'practice-theory gap', their places of practice, and conditions of employment vary widely throughout the world. This review examines some of these roles, with the objective of examining strengths and weaknesses associated with different models of employment/deployment, with a view to informing NHS Education for Scotland (NES).

Methodology

The review identified English language literature published from 2000 onwards, primarily from UK, USA, Canada, Australia and New Zealand, pertaining to models of employment/deployment of nurses in practice-education roles. Databases searched were CINAHL, Medline, BNI, Scopus,

Web of Science, PsycInfo, and NHS Scotland e-library. The internet was also searched to identify any relevant grey literature, practice guidelines, reports etc. The following search terms were used: evaluation; costs and benefits; effectiveness; joint appointment; honorary contract; adjunct professor; honorary lecturer; honorary professor; practice educator; clinical faculty; clinical academic career; clinical teacher; clinical nurse educator; lecturer practitioner; nurse practice education facilitator; link teacher; link lecturer.

Approximately one hundred and fifty articles were initially identified, of which 85 were obtained and read, and approximately 75 included in the review. The majority of studies were from the UK and the US, and identified different clinical, but related, roles in each country, such as liaison of nurse education, teaching, clinical practice and clinical supervision. Subsequent to integration with universities, more recent UK studies have focused on the altered role of nurse educators, preparation for their new role, and maintaining clinical competences. US studies have explored models for the nurse educator's clinical role, factors that facilitate/inhibit its fulfilment, and their relationship to teacher role strain (Griscti et al. 2005). Very few studies were identified that gave any focus to job descriptions, role descriptions, career paths or contracts.

The remainder of the report is in eight further sections:

2. Background
3. Models of Collaboration and Integration
4. Titles, Roles and Definitions
5. The Education Component
6. Evaluation of Impact
7. Career Pathways
8. Canada/ New Zealand case study
9. Conclusions

2. Background

Historically, nurse education and training in the UK was delivered mostly in the form of an apprenticeship model, with practice education provided mainly by the ward sister, with support from a representative from the local college of nursing, sometimes called a 'clinical teacher'. The clinical teacher role was phased out in the mid 1980s, reportedly owing to inadequate role description and conflicts between service and educational needs (Aston et al. 2000).

This model changed fundamentally in the 1990's. A change in nurse education policy meant the assimilation of nurse education into higher education (Aston et al. 2000). The responsibility for clinical support in practice areas now lies mostly with a designated mentor, and in Higher Education, sometimes by jointly appointed lecturer practitioners (LPs), which has led to an array of different models for joint appointments (Leigh et al. 2005). Both

lecturer and mentor perform a supportive and teaching role in the ward setting (Gillespie & McFetridge 2006).

There has also been an increase in new support roles including clinical facilitators, clinical liaison lecturers and practice placement facilitators (Mallik & Hunt 2007). For an in-depth review of the literature relating to clinical education, see Pollard et al. (2006).

Tensions between Practice and Education Roles

The shift of nursing education from healthcare organisations into higher education has often led to a geographical separation between the educational establishment and the service areas used for practice placements (Aston et al. 2000), and has reduced the ease of contact which nurse educators have with clinical areas. In addition, the multiplicity of roles that lecturers are required to fulfil, and the reduced time available for practice have reportedly led to conflicting demands on their time, resulting in nurse educators struggling with a balancing act of being a nurse and being a teacher in the academic setting (Carr 2008). This necessitates prioritisation of tasks and can lead to certain aspects of the lecturer's role being neglected, an example being supervision of students in the practice setting, which is a key facet of their remit. One study reported the majority of educator respondents believed the incorporation of their role in practice into higher education to have had negative effects, and they wished to engage more in the practice of nursing (Goodman et al. 2006, p. 442).

There is a view that some joint appointment staff feel that the gap between academics and clinicians is widening, rather than lessening (Deans et al. 2003; Carr 2007), and that on occasion there is pressure to choose between practice and education, which can lead to a feeling of deskilling among nursing academics with regard to their clinical expertise (Goodman et al. 2006). Carr (2007) goes as far as to say that "the longer a nurse works as a teacher in higher education, the less likely they will be to maintain any clinical practice" (p. 898).

The shift from clinical-based training and education into academic institutions has been paralleled in other countries, such as the US, Canada and Australia and elsewhere. Nurse education in Australia became part of the tertiary education sector in the mid 1980s, where the role of clinical teacher with hands on involvement in clinical practice was superseded in 1990s by the liaison role (Conway & Elwin 2006). Unlike the UK, universities in Australia are financially responsible for supporting pre-registration students in clinical practice and employ clinical nurse educators for this purpose. Mallik & Aylott (2005) indicated that universities were continuing to have difficulty in providing clinical placement experiences for students within their existing budget resources. Some studies have recommended that Australia adopts the UK partnership model whereby university and practice staff support students in clinical learning (Pollard et al. 2006). In their strategic review of undergraduate nursing education in New Zealand, KPMG Consulting (2001) made the

recommendation that 'education and service providers be encouraged to demonstrate commitment for shared responsibility to undergraduate education through establishing joint appointments or equivalent arrangements' (p. 95).

3. Models of Collaboration and Integration

Approaches to the integration of theory and practice vary widely, ranging from individual joint appointments to collaborative approaches between academics and practitioners (Andrew & Wilkie 2007). At an organisational level, a typology of models of clinical-academic collaboration can be determined (see Beitz and Heinzer 2000; Saxe et al. 2004, Murray 2007).

- **Entrepreneurial/linkage model** – nursing school establishes a contractual arrangement with organisation whereby the school provides services to the agency for a fee. The clinician/administrator/researcher remains University employee, and University pays salaries. This model can have several benefits to the University – may help meet improving patient care, promoting faculty's clinical expertise, maintaining an up-to-date curriculum, and creating opportunities for collaborative quality improvement initiatives and clinical research. The community agencies and clients also benefit, by receiving expert clinical services, augmented by students, access to evidence-based practice and opportunities for research. This model limits University financial liability because it does not rely on gathering fees from underinsured population, but the major disadvantage is that the school/department may have limited opportunity to participate in agency decision-making.
- **Unification model and collaboration model** – faculty have appointments as both practising clinicians and teachers but in the unification model, the dean serves as both head of the nursing school and administrator of the clinical agency. Financial support is not necessarily shared between two organisations. Benefits to academic institution include maintaining faculty members' professional skills and preserving institution's credibility by having faculty in service roles. Benefits to clinical site include improved patient care and education, staff development, improved clinical management, and application of academic knowledge to improve services, in addition to the other benefits noted under entrepreneurial/linkage model. Competing demands between service, teaching and/or research can be challenging as the primary customer in the clinical setting (client) is different from the primary customer in the academic institution (student).
- **Integration model** – faculty as well as nursing students give direct patient care. Financial support may or may not be shared. Despite the potential for revenue generation, the biggest disadvantage of this model is the threat of financial losses. This model allows the school/department the greatest degree of control over the operation,

and direction of practice, in addition to the benefits noted under the entrepreneurial/linkage model. The biggest disadvantage is the threat of financial losses.

- **Moonlighting model and Private practice model** – faculty are directly reimbursed for their services for work performed on their own time. Private practice models can be negotiated in group practices (e.g. nurse practitioners with private physician groups). No financial benefits accrue to the school. This model has the potential to address all of the benefits related to nursing student education, client care, clinical research and practice innovations as noted in the entrepreneurial/linkage model, but as it is often dependent on profit-sharing and productivity expectations, the ability to meet teaching practice, service and research role expectations is challenging.
- **Joint appointment model** – faculty have mutually established responsibilities in both academic institution and practice agency. School and agency form a partnership with a totally separate administration in each. Joint appointees salaries shared by both. Joint appointment may be called shared or adjunct appointments. Advantages to the service agency include cost savings, educational opportunities for staff, new perspectives on clinic administration and management, and application of research to improve practice along with the benefits of the entrepreneurial/linkage model. However, faculty members contribute less time to teaching and other academic responsibilities than with other models, and they also face issues of time management and role strain.
- **Nurse-managed centres associated with colleges/universities** are a newer innovative model for faculty practice. Not structured as an appointment between two different organisations, faculty can practise in advanced clinical roles within the educational institution's affiliated centre. Clients reimburse the centre directly for services received from faculty.
- **Collaborative practice/education partnership** Hospital paid (donated) masters' clinicians used as clinical faculty; online course used for delivery for non-clinical theory nursing courses, converting existing masters nurse educator programme to an online format to increase the supply of nursing faculty, and expanding and better equipping nursing skills laboratories.

(Derived from Beitz and Heinzer 2000; Saxe et al. 2004, Murray 2007).

The model most commonly described in the nursing literature is the **joint appointment**, which has been in existence for the past 30 years, and also some instances of the **integration** model (Dunn & Yates 2000). Within the UK, one model found was the Bournemouth Collaborative Model, a partnership initiative designed to support pre-registration nursing students in practice placements (Mallik & Aylott 2005). The authors compared this with the Australian model of support for student nurses in practice, where university employed clinical facilitators, experienced practitioners and/or academic staff were employed on a sessional basis. Findings are summarised in the table below:

Table 1: Comparisons between UK (BCM) and Australian model of support for student nurses in practice:

UK (BCM)	Australia
Ratio 1:30/50 students to Practice Educator (PE)	Ratio 1:8 students to Clinical Facilitator (CF)
Ratio 1:1/2 students to qualified mentor	RN 'buddy' but variable allocation except for Dedicated Educational Unit (DEU) model (Flinders University)
Formal mentor preparation required by professional regulator (NMC)	No formal programme for CFs and preceptors of third year students
Longer placements in practice	Very short focused placements 'off campus'
Limited skills laboratory facilities	Extensive skills laboratory facilities
Continual assessment throughout with practice profile and one exam	Extensive examination throughout with Objective Structure Clinical Exams (OSCEs) to assess practice competence
PEs/LLs complement the mentors' assessment of practice competencies	CF employed by university to undertake all student clinical assessments
Educational auditing of the learning environment of placement areas is a well-established practice	No auditing of placement environment

(Mallik & Aylott 2005, p. 157)

In the UK, PE's are used as an extra level of support to enhance the student experience, support the mentor and promote the links between the Trust and HEI. In Australia, the CFs have a combined mentor/assessor and facilitator role and although students are sometimes 'buddied' with a RN for a shift, there is no formal process of preparation for these 'buddies'. The authors suggest the potential for an approach which would take the best from the two models. There could be an increase in the number of students allocated to a qualified mentor in the UK who has a team of associate mentors (similar to the 'buddy' system in Australia). This mentor should be remunerated accordingly with allocated time to undertake the role through a reduction in patient care management time.

4. Titles, roles and definitions

Models of collaboration and integration will impact on the roles of individual staff. This section examines examples of various roles and their implementation at the practitioner, rather than organisational, level. Nursing education is no longer limited to those that have 'education' in their position title, and there is reportedly evidence of role blurring and confusion among a number of classifications of nursing staff (Conway & Elwin 2006). Implicit in the roles of clinical nurse specialist, clinical nurse educators, nurse educators

and clinical nurse consultants is educational support for learners. However, the lack of explicit role demarcation among these professional groupings in nursing can contribute to limited role identity or to role confusion for some staff.

Definitions

Table 2: UK Definitions of Nurse Education Terms and Roles

Clinical teacher	Existed in 1970s to very early 1980s. Was responsible for supporting students on placement and teaching clinical skills in the school of nursing
Lecturer practitioner	Emerged in late 1980s. Aim was to respond the problems inherent in the clinical teaching role, e.g. poor career progression and ambiguous status within service and education. Would have a substantive post in practice and education, with a joint contract between a hospital or primary care organisation and a higher education institution (HEI) with usually a 50-50% weighting
Link lecturer	Has responsibility for ensuring that the educational milieu of their designated link practice areas supports student learning during placements
Practice educator	Has strategic responsibility for educational development within practice. May hold a joint contract between the hospital/ organisation and the HEI, but, unlike the LP, this tends to reflect a 80-20% weighting respectively
Clinical facilitator/ manager Practice Development Nurse	Exact title varies, but generally, the role holder is responsible for clinical skills teaching in the HEI and supporting students on placement in achieving their clinical competencies. Induction and CPD of staff in unit.
Practice placement coordinator	Title can vary but, generally, the role holder is responsible for the management of placements. This involves creating new placements for students, identifying how existing practice placements meet the learning outcomes of students at different stages of the pre-registration course, and alerting the HEI to gaps in provision
Practice Education Facilitator	Scotland, from 2004. This role comprises elements from several of the above roles, such as supporting links between practice placement area and Link Lecturer, and identifying opportunities for interprofessional learning within the clinical environment. The main focus is on supporting the education and development of mentors and developing the clinical learning environment.
Joint appointment	Existed predominantly in 1980s. Was often a Ward Manager/Clinical Expert and would support professional development in their area and have

	teaching responsibilities in the school of nursing
Honorary academic appointment	Clinical practitioner or manager also has an appointment with HEI- may be a title only, or may have limited or substantial role in contributing to education/ policy development/research.

(Modified/adapted from Ramage 2004, p. 289)

The above roles could be viewed on a continuum with at one end the lecturer/practitioner primarily focusing on the academic/educational interface to practitioners or managers with honorary appointments at the other. The clinical practice based and oriented clinical facilitator, clinical practice manager or practice placement coordinator based fall in between these two ends of the continuum, but are oriented towards practice as their primary focus and locus. The role of Practice Education Facilitator (PEF), as defined by NES (see page 1), also has primary leanings towards the practice-based and organisational end of the continuum.

Another term discussed frequently in the literature, and alluded to earlier, was that of a mentor, which has been defined as 'A nurse, midwife or health visitor who facilitates learning and supervisors and assesses students in practice (ENB, 2001b, p6). This role has not been included in the review as it does not generally involve working in more than one place or organisation, however the part played by these practitioners in supporting students, and often joint appointees, should not be overlooked. Other roles which are also related, as defined by NMC (2006), are sign-off mentor, practice teacher and teacher.

Examples of Different Roles

Joint Appointment Roles

Whilst in the UK there is no consensus regarding a definition for a joint appointment, it has been described as "A collaborative approach whereby two organisations engage in negotiated employment of a nurse or a midwife." (NCPDNI, 2005, p.2). Joint appointments can take many forms; they can be focused on clinical practice, sharing of staff to teach, and/or research.

For example, Springer et al. (2006) instituted a joint appointment in a bid to improve the research activity of their institution. The faculty was to act as research resource to staff, promote evidence-based practice, and support the faculty's research agenda. Mutual goals were agreed upon with the joint appointment. The clinical agency had the benefit of a doctoral-level nursing faculty who spent dedicated time in the organisation, and helped to establish, maintain and grow a sound evidence-based practice. For the academic institution, the faculty was able to use research skills in a clinical setting. This project utilised the entrepreneurial model whereby the clinical facility paid the University for a certain number of faculty hours per week, which facilitated the hire of adjunct faculty to alleviate the teaching load of the research faculty. The project was deemed successful, and three further appointments were instituted, on the back of some important lessons learned. These included establishing a contact right from the beginning, meeting frequently to ensure

all parties' needs are being met, not being focused on one project to the exclusion of potential collaborations between staff and faculty, and monitoring the work being done and letting others know about the projects.

It has been highlighted that joint appointments can be facilitated by four enabling factors; mutual accountability; view of both roles as one entity; compatible role expectations; and recognition of clinical practice as value for tenure and promotion prospects (Camsookai 2002).

According to Larrabee (2001), achieving the desired outcomes requires envisioning, executing, evaluating and evolving the dual roles by the employers and the appointee.

Components of these facilitative factors were summarised by the Nursing Council for the Professional Development of Nursing and Midwifery (Eire) as follows:

- Visionary leaders/managers
- History of partnership between working organisations
- Managers from both organisations negotiate and plan:
 - Role responsibilities
 - Integration of roles into one job description
 - Resources/funding
 - Selection and recruitment
 - Administrative support
 - Access to post holder
 - Induction
 - Performance appraisal
 - Training and development
 - Evaluation of outcomes

(NCPDNM 2005, p. 9.)

Lecturer Practitioner

A Lecturer Practitioner (LP) is a joint appointment between a hospital/NHS employer and a university with a responsibility for nurse education, both in academia and in practice. The role covers education and support of professional development of nurses within a clinical area, and involvement or responsibility for clinical development within that area (Camsookai 2002). It means having to juggle two equally important, but often competing goals – to prepare students for role of professional nurse, and to maintain safety and well-being of patient (Allison-Jones & Hirt 2004). Dual focus requires special and distinct teaching skills or characteristics which are developed over time – lecturing and practising and a dual/joint appointment. Salvoni (2001) stated that lecturer practitioner partnerships have tended to focus operationally, at clinical manager level or below, and that there is little evidence of a consistent approach to joint working and a lack of commonality and understanding about role focus. There are also the difficulties of having to answer to two employers and meeting the expectations of both, whilst developing and maintaining the

two roles at a credible level (Salvoni 2001; Fairbrother & Mathers 2004; Hancock et al. 2007).

As a result of the diversity of the role, it is difficult to identify experiences and competencies required of nurses functioning in the role of LP (Leigh et al. 2005). In their qualitative study of diary keeping by two LPs, and semi-structured interviews with seven stakeholders, they found evidence of great job satisfaction on the part of the LPs, introduction of new practice initiatives and staff development programmes from the practitioners' point of view, and quality input by LPs into curriculum development from participants in higher education. However, there was a lack of collaboration between organisations, particularly regarding the initial role development, which led to role ambiguity. The authors concluded that new roles are emerging to meet the needs of the changing population and innovations in the curricula, for which new practitioners are being prepared, which they suggested could lead to the LP role becoming obsolete.

Practice Educator

Increasing emphasis has been placed on the role of practice educator, i.e. an educationalist based solely within the clinical area, taking responsibility for the coordination of student experience and the assessment of learning and mentor preparation and support, responsible for supervision and assessment of the student in practice (Magnusson et al. 2007). The authors concluded that as practitioners are being prepared for these new roles, which should lead to improvements in practice education standards, the role of lecturer practitioner could become obsolete. Within Scotland, the Practice Educator Facilitator (PEF) was introduced in 2004, to support practice-based learning within the clinical environment, and, and is currently undergoing evaluation. PEFs provide support to the mentor, help coordinate student learning objectives, and facilitate a more meaningful experience for the students. Some are based on wards, others hold more managerial posts. There are full-time and part-time posts, and some community PEFs, who cover large geographical areas. The posts were initially funded for three years (and have now been made substantive) via an agreement between the (then) Scottish Executive Health Department, NHS Scotland and the Higher Education Institutions. PEFs have contributed to HEI curricula, and have detailed knowledge of the specific characteristics of various universities. A number are studying for a post-graduate certificate in education, but more often, they are experienced clinical nurses with some teaching or management experience. There is some sense of a loose career pathway, whereby a practitioner could become a mentor, then a sign-off mentor, then a practice education facilitator, and then possibly use these qualifications as a platform for HEI posts (NMC guidelines, 2006).

Link Lecturer/Teacher

The role of link teacher in clinical practice was investigated by Ramage (2004) over a seven year period, involving 28 in-depth interviews with nurses with a range of educational roles, employed in educational settings and practice settings in the South of England. She found that link teachers had to negotiate multiple role relationships with others because there was no consistent

definition of their role in the clinical settings. Link teaching roles evolved through the dynamics of social relationships with others and the socialising influence of the practice and educational organisations. She concluded that novice teachers will need to be educated about concepts such as change management and the influence of social groups on role development.

Clinical Facilitator

Historically, the role of clinical nurse educator (CNE) or clinical facilitator (CF) has been associated with a training model of nurse education. One UK example of a practice-based post was a study by Brennan & Hutt (2001) which gave a detailed first-hand account of the authors' experiences of being appointed clinical nurse educators (described in more detail below).

The postholder plays a pivotal role in negotiating partnerships between the university, students and the nurses and managers in clinical areas to create favourable conditions for learning. In the USA, the faculty members accompany students to the clinical areas to provide mentoring relationships with positive outcomes. In Australia and Ireland the clinical facilitator (CF) and clinical placement coordinator (CPC) are based in practice. The CF combines the facilitator and assessor role, whilst in Ireland, the CPP facilitates students to apply theory to practice in partnership with educators and clinicians. In the UK, the clinical educator tends to be based in acute hospital settings.

An Australian study evaluated the impact of two CNEs in an emergency department over a six month period. The posts came about because of an inappropriate nursing skills mix due to shortage of nurses with specialist qualifications in emergency nursing. The reported levels of knowledge of nurses increased for all areas of emergency nursing, along with an increase in reported adequacy of in-service education, level of clinical support and satisfaction with current level of knowledge in emergency nursing (Considine & Hood 2000).

Approaches to supporting learning in child health nursing in New Zealand and the UK were examined by Maiden and Hewitt-Taylor (2005) compared. In New Zealand, the term clinical nurse educator is used to refer to roles which link theory and practice. CNEs provide direct teaching and act as role models to students, have significant input into facilitating the in-service education of new graduates and are involved in decision making regarding course content and participant needs. They also facilitate the ongoing education and development of trained staff, and have a management role, which may assist in implementing change. The authors felt that the tendency for joint education/service appointments in New Zealand to be clinically based may result in less role conflict and greater sense of identity.

Twelve CFs in acute and surgical wards were established in six NHS Trusts in northern England (Rowan & Barber 2000). The role specified that they should be "clinically credible practitioners who would function to enhance and improve the clinical competence of student nurses" (p. 35). The role focused on working with and directly supervising students in the clinical setting. The facilitators were seconded for 12 months from clinical placement areas, and

were supernumerary to the wards enabling them to work alongside the students. They also worked with ward staff to enhance the pre-registration students' clinical experience. This particular project utilised a partnership created with education, whereby the clinical facilitators regularly discussed the students' experiences with the link tutor, enabling continuity of educational evaluation, and early identification of problems or areas of concern for the link tutor to act on. The authors suggested that the clinical facilitator/link tutor partnership could offer an alternative model to that of lecturer practitioner, where, rather than diluting the skills of teacher and practitioner, this model could offer an opportunity for those keen to embrace mutually collaborative ways of working, thereby enhancing each other's skills and roles. There is an overlap between the CFs described in this study and the role of PEFs in Scotland.

In their literature review of clinical education facilitators (CEFs), set within an Irish context, Lambert & Glacken (2005) found that there was considerable lack of role clarity relating to what constituted clinical facilitation and the role of the clinical educator. The clinical educator role was introduced to raise the profile of clinical education (Milner et al. 2005). Lambert & Glacken (2006) described a clinical education facilitator (CEF) as 'An experienced nurse, employed within assigned clinical areas, supernumerary to the ward team and solely responsible for clinical education and support' (p. 359). This echoes the sentiments of Considine & Hood (2000) who stated "The provision of clinical education and support is not possible without a supernumerary person with skills and knowledge in both education and [emergency] nursing" (p. 78). Extraneous to the workforce, supernumerary status assists in overcoming the conflicting demands placed on the clinical educator role, whilst reflecting the importance accorded this role (Pollard et al. 2006).

Practice Placement Facilitator

The role of Practice Placement Facilitator (PPF) was evaluated by Clarke et al. 2003. These joint Trust and University post holders had responsibility for placements, supporting students and mentors, and ensuring that placement were properly audited. In this study, three posts were established, whereby the postholder (who had previously worked in a NHS Trust as a practitioner) worked in the trust and was seconded to the university for the duration of the post. The PPFs were managed through the university but maintained organisational links in their Trust. The study evaluated, over 12 months, the impact of the PPF on the provision of student placements, student support during placement and the professional development needs of clinical staff as mentors with student supervision and assessment responsibility. Despite being greatly valued both by the students and clinical staff, by improving familiarity with the curricula and providing continuity throughout different placements, PPFs felt misaligned with both their Trust and the University. They experienced tension resulting from the ambivalent organisational location, and the short term nature, of the posts. There was also potential overlap between the role of the PPF and the clinical liaison teachers, with further definition and purpose of both roles needing to be developed and articulated.

A similar role, but with a different title, Clinical Placement Manager (CPM), was explored by Magnusson et al. (2007). This role was introduced to respond to the NHS Plan (2000) which stipulated a large growth in the number of students undertaking professional health education programmes, which resulted in the need for increased numbers of clinical placements. The role of the CPM was to facilitate the development and expansion of placement capacity, and increase the quality and quantity of clinical placements, by linking HEIs, students and clinical areas. The majority of CPM participants, numbering seven in total, had been in post for two to three years, and all held professional qualifications, with considerable practitioner NHS experience. Many had taken different education/teacher training courses, and others had worked as clinical teachers or in practice development roles. Their core responsibilities included: forming partnerships with the universities; supporting mentors to ensure students achieved their aims and objectives; supporting and guiding students; developing the learning environment; acting as a Trust representative at the university; feeding back curricula changes and university updates to the Trust; supporting managers in the Trust; and acting as liaison between the placement area and the placement office at the HEI. The researchers found that CPMs felt the need for a closer working relationships with university staff, in order to understand where placement could fit into the curriculum. An approach suggested by one participant was to hold a stakeholder workshop, with attendees from the university, Trust and independent sector, to map out all the types of potential placements, and then look to see how they could fit into various programmes. The CPM role operated at an organisational level to promote 'joined up thinking' between partners to ensure that structures and processes are in place to facilitate student learning in practice placements, and has similarities with other UK examples (Mallik & Aylott 2005; Murray et al. 2005).

In the Republic of Ireland, Clinical Placement Coordinators (CPCs) (An Bord Altranais 2003) provide student support for all issues while on practice placements. They do not take on the direct patient contact clinical teaching role of the practitioner. These roles have become clearly defined and accepted by all key stakeholders. A CPC is required to have 3-5 years clinical experience, which must have included supporting students in the workplace for 2-3 years. A degree is recommended, though not essential.

Senior posts

Australian chairs in clinical nursing have been established in order to achieve more effective partnerships between academia and the health care sector in education, research, and quality of nursing care (Dunn & Yates 2000). A clinical chair is a joint appointment at the professorial level with links to both academic and clinical settings. In the UK, there are a growing number of joint appointments at a senior level e.g. Assistant Director of Nursing (Butterworth et al. 2004, p. 27).

Clinical faculty

US literature tended to use the generic term clinical faculty to describe nurse educators, though some specific titles were also used – e.g. affiliate faculty (Murray 2007); adjunct faculty (Peters & Boylston 2006); joint appointment

(Springer et al. 2006). Faculty practice has been described as “a formal arrangement between a school of nursing/academic health center and a clinical facility/enterprise/entity that simultaneously meets the service needs of clients, while meeting the teaching, practice, service, and research needs of faculty and students” (Saxe et al. 2004, p.166).

5.The Education Component

Conway and Elwin (2006) warned of the danger of a climate which valued clinical nurse educators maintaining their identity as expert clinicians and negated their educational expertise. They highlighted the importance of formalised support for CPD in clinical practice. A significant number of CNEs in their study felt that many nursing unit managers appeared to place emphasis on clinical expertise and skill development at the expense of developing critical inquiry, which then created role tensions for them as clinical educators.

Much of the literature relates to the clinical nurse educator's role focusing on support of undergraduate student nurses in the clinical setting with little exploration of their role in supporting CPD of the post-registration nursing workforce. In another Australian study, Manias & Aitken (2005) asked 37 clinical teachers about their preparation for their clinical teaching role in a large university with large numbers of enrolled specialty postgraduate students. Previous experience as a specialty nurse was reported as being the most effective preparation strategy for their role, and the clinical teachers perceived their role as primarily to bridge the theory-practice gap, and ensure relevance of the curriculum. Nearly two-fifths of the CTs lectured at the university in addition to providing clinical support, suggesting that the model of seconding clinicians to the clinical teacher role could provide a better solution to narrowing the gap than university lecturers attempting to include clinical practice in their role. Support for this finding was provided by Carson & Carnwell (2007) from their study in Wales.

Within community nursing, Clay (2002) outlined a flexible programme, the Plymouth framework, which was developed to facilitate learning and assessment of student community health care nurses, taking the contribution of existing community practice teachers (CPTs) into account. Community specialist practitioners who wished to undertake mentorship at first degree or masters level were able to access a specialist practice mentor route, with the option to progress to the full practice educator programme. Within community nurse education, the role of the CPT has been important in the preparation of new specialist practitioners (Stevens 2003). However, the role is somewhat of an anomaly and has lasted as a facilitator of learning on a one-to-one basis for those intending to become specialist community practitioners, but will be augmented by practice educators in order to more effectively support and supervise mentors.

In an attempt to address the development needs of faculty members within a clinical education institution, one study described the development of a

biannual faculty development day (James 2004). The programme had the following five aims: 1) to provide a venue for faculty to increase and update their knowledge regarding nursing practice at the medical centre, 2) review and discuss the role of faculty, nursing students, and medical centre staff sharing clinical experiences at the medical centre, 3) introduce basic concepts of computer use and working with the electronic medical record, 4) create networking opportunities for nursing faculty, nursing education specialists and nurse managers at the centre, and 5) increase collaborative efforts between nursing practice and education to prepare the professional nurse for the future. Forty participants from five different affiliated colleges and universities attended. Owing to the success of the workshop, a second faculty development day was developed and run 7 months later, containing information relating to, for example, nursing practice changes, new educational initiatives, initiation of online student registration system, and an opportunity to network with nursing education specialists from the medical centre. The project demonstrated how clinical education settings provided faculty development opportunities for nursing staff, and that such development days were an efficient way to help nursing faculty maintain their practice skills and knowledge.

Kelly (2006) developed a clinical faculty role questionnaire and used role theory to investigate clinical faculty in 41 baccalaureate nursing programs (n=134) throughout the northeastern and mid-Atlantic United States. She looked at what constituted appropriate preparation for the clinical educator role, but found no relationship between highest degree held and faculty perception of being prepared for clinical teaching, and faculty's understanding of the clinical educator role. However, there was a significant difference in the use of teaching strategies between faculty holding a doctoral degree and a masters degree, with the former scoring higher in use of teaching strategies. These differences were attributed to the clinical focus within a masters degree, whereas doctoral programmes may have provided preparation for the teaching role. Teaching experience may contribute to the development of the clinical faculty role more than formal education, and individuals who remain in the clinical faculty role over time do develop teaching abilities. She concluded that clinical faculty needed to be exposed to teaching theories and strategies that facilitated student learning so that they were then implemented in the clinical setting.

Kowalski et al. (2007) evaluated a programme designed to address the shortage of clinical faculty available to prepare new nurses in Colorado. The programme prepared staff nurses to assume the role of 'clinical scholar', defined as "an expert clinical nurse who meets the educational preparation requirement for the contracting educational program" (p. 70). The clinical scholar was released from their clinical role and assumed full responsibility for coordination, clinical teaching, and evaluation of a (rotating) group of nursing students. They worked in collaboration with school of nursing faculty who coordinated the programme, and made periodic site visits to the clinical agency, but were based at the school of nursing. The clinical scholar maintained their usual employment status within the facility, on their existing salary and benefits from their home facility, which was reimbursed by the

schools for time contracted, with grant funds available to reconcile differences where they existed. Course content was developed by a curriculum committee comprising members from service, academia, and the Colorado Center for Nursing Excellence staff.

The course was set up to educate and support 45 clinical scholars, but such was the demand and positive feedback from the initial 33 participants, that an additional two scholar courses were offered and an additional 91 clinical scholars trained. The course lasted for 40 hours, and was run over a five day period, and covered five main areas of content. The course was evaluated from the student perspective on a daily basis and individual faculty members were also evaluated by the students. The evaluation committee developed tools to collect ongoing data from students, scholars, schools and clinical agencies. Many benefits of the course were noted, including to the clinical scholars, the service providers (particularly those in rural areas), nursing students, and academic institutions. These included giving scholars renewed interest in their work, better quality of care provided to facilities, enhanced learning environments for students, and more clinical faculty members with appropriate skills available to nursing schools. Challenges for service providers include release time for participants, time required for preparation for students and subsequent evaluation and grading of assignments. Challenges for schools include difficulties for clinical scholars to meet with course faculty or attend other academic functions, and difficult to arrange meetings and communication with faculty regarding student progress. Clinical scholars require formal mentoring from experienced educators, which is often not available. Financial problems may occur if no top-up funding available to balance pay differentials between academia and service providers. But the programme looks to be a winning one for all concerned.

The promotion of academic and research skills in the clinical area is important to both nurses and nursing, but continues to be held back by a lack of expertise in these areas at the clinical level, perpetuating the so-called 'theory-practice gap' (Considine & Hood 2000). Rattray (2004) emphasised the importance of practitioners receiving guidance in developing teaching materials and feedback on teaching performance itself, which can be provided by lecturers. She suggested that reciprocal arrangements could be made for lecturers to be seconded back into practice, which would give both sides the opportunity to collaborate and enhance the future of clinical education. In future, fewer lecturers might be based solely in HEIs and a new nurse academic could be developed who could easily move between the two cultures.

Preliminary results from the NHS Education for Scotland evaluation (NES 2006) showed that the majority of PEFs were achieving the core role competencies in relation to identification, selection and evaluation of practice placements for students. Part-time status was viewed as a possible limitation but the survey was undertaken at an early stage in the implementation of PEFs and more detailed information will be available in 2008.

6. Evaluation of Impact

Overall, there is little in the way of robust evidence that evaluates the effectiveness of the various types of clinical educator roles (Pollard et al. 2006; Hancock et al. 2007). The literature reports variously on the benefits of joint appointments relating to the joint appointee, the faculty, the agency, the student and the profession, but much of the information is anecdotal (Ogilvie et al. 2004). Most studies examined in previous reviews involve some form of measurement but the robustness of the methods used varied, as did the success criteria- and few studies investigate the reasons for improvement, or how it could be implemented. Generally the focus has been on the impact on educational component, rather than the effect on practice itself. This may be a reflection of the locus and priority of those conducting the research and evaluation.

Studies often used a mixed method approach, using tools such as student evaluation forms; educational audits; personal perceptions of relations with staff and students; verbal feedback from practice staff; questionnaires; and requests from practitioners and/or students for practice input. Several studies sought feedback from students as the main form of measurement (Ramage 2004; Wolf et al. 2004). In their qualitative study, Wolf et al. analysed 317 instructor evaluation forms, and found several patterns and themes, relating to positive and negative perspectives. Faculty performance strengths included being a knowledgeable and strategic teacher, creating a positive learning environment, demonstrating professionalism, displaying scholarly traits and being supportive. Weaknesses included poor delivery of content, not being organised, being inaccessible, displaying weak teaching skills, being unprofessional and displaying negative traits.

Other studies used student feedback in conjunction with clinical educators' perceptions (Lee et al. 2002; Allison-Jones & Hirt 2004). These researchers used the Nursing Clinical Teacher Effectiveness Inventory (NCTEI), and found few differences across all five subsets, although Lee et al. (2002) did find some age-related demographic differences, whereby mature students emphasised the need for performance feedback, particularly those who had prior nursing experience, whereas younger students were more sensitive to criticism. Managers were more rarely included in evaluations (for example, Williamson & Webb 2001; Clarke et al. 2003; Mallik & Hunt 2007). In their study which looked at the effectiveness of clinical nurses employed in support roles for students in clinical practice in one UK HEI and its linked NHS Trusts, Williamson & Webb (2001) found that the roles were successful in bridging the theory-practice gap for HEI and Trust managers, but not so successful for the students. It was felt that more needed to be done to extend the benefits to students' learning in practice settings.

A joint initiative between an English university and its NHS service partners developed the Practice Educator role to support practitioners who supervised students' learning in practice, and to act as a role model for students (Jowett & Mucullan 2007). The study evaluated the role from the perspective of the practice educators themselves (n=24), mentors (n=97) and students (n=131),

using a combination of quantitative and qualitative methods. Findings indicated that practice educators were seen as supportive to both mentors and students and perceived as a vital link between the University and the practice environment, a view held by the practice educators themselves. They were seen as credible practitioners, approachable and accessible, which helped provide a clinically credible and responsive educational presence in practice. Difficulties working for two organisations were mentioned, with one person saying they felt stuck in the middle, but this was not raised as a problem by other PEs.

In Eire, Lambert & Glacken (2006) carried out a qualitative investigation of the clinical education facilitator (CEF) role, from the perspective of the clinical education facilitators themselves (n=10) and post-registration paediatric student nurses (n=5). The CEF role emerged as diverse, complex and multifaceted, with the CEFs using four main strategies to make the clinical environment function an effective learning environment for the students. These were facilitating transition; maximising learning opportunities; preparing the clinical environment; and providing support. Challenges identified by the CEFs were profuse role perceptions, excess workload and concerns regarding clinical visibility, which in turn relates to the debate as to what a CEF should do, as there is no framework to follow. Across the border in Northern Ireland, McCormack & Slater (2006) evaluated the role of clinical evaluation facilitator to see whether they made a difference to the learning experiences of nurses in a large teaching hospital. They found that whilst the CEFs had played an important part in the active coordination of learning activities in the hospital, there was little evidence of the role directly impacting on the learning culture of clinical settings. They suggested that classroom based learning alone would not be able to create a culture of development in nursing and that there was a need for work-based learning models to be integrated into practice environments.

Mallik & Hunt (2007) reported on a process evaluation of a practice education team in an acute hospital in England. This method allows exploration of changes and development of a programme following implementation which facilitates contextual interpretation of outcomes. The practice educators recruited had local clinical expertise, and undertook further personal and professional development whilst in post. The emphasis was very much on education, with clear expectations with regard to clinical credibility, role modelling, clinical skills teaching and support of clinical effectiveness in each of the four learning localities. Eighteen semi-structured interviews were carried out with directorate senior nurses, the acting director of nursing services, and clinical managers. Eight key themes emerged from telephone interviews: qualities needed for being a successful PE; providing a link with the university; 'plugging a hole' in supporting learning needs; visibility and presence of PEs; being a team member, guest or stranger; providing relief to practitioners in dealing with the 'burden of students'; alleviating the 'plight of students'; and effects on student attrition. Findings provided evidence for the continued funding of the practice educator role with improvements necessary in dealing with stakeholder expectations.

Self-evaluation was another method used, whereby individuals who had taken on the role of a clinical educator in one form or another, recounted their experiences and related both positive and negative aspects (e.g. Salvoni 2001). Brennan & Hutt (2001) were appointed to two new educator roles, one a Return to Practice Support Nurse, the other an Education Development Nurse, within their local trusts (one appointment was a joint appointment between the two trusts), with very close collaboration with the local HEI. Difficulties they faced included working in diverse clinical settings (often new to them), not being part of the nursing team, having to deal with situations which conflicted with their facilitative remit, and of being the clinical “Jacks of all trades, masters of none” (p. 184). Their experiences led them to suggest that the key to the success of these posts was recent clinical practice, and that they would make a good 6-9 month secondment for nurses interested in education and practice development, but who wanted to stay in practice. They also felt it essential that an educator had recent experience of working with students and assessing nurses in practice.

Considine & Hood (2000) undertook a 6 month study in Australia to investigate the effects of their appointments as clinical nurse educators in an emergency department. The study aimed to identify the educational needs of nursing staff, self-reported levels of knowledge of nursing staff, the perceptions of nursing staff surrounding education and clinical support and to compare responses over the 6 month period to identify any statistically significant changes. Evaluation was carried out by means of a self-administered questionnaire, developed following discussions with key personnel, which was distributed at three intervals. Overall, increases were found in the reported levels of knowledge for all areas of emergency nursing included in the study; and the reported adequacy of in-service education, level of clinical support and satisfaction with current level of knowledge in emergency nursing.

A phenomenological study using in depth interviews with five clinical facilitators in the University of Sydney was undertaken to investigate the lived experience to see how facilitation took place in the clinical environment (Dickson et al. 2006). The researchers discovered five ways in which participants facilitated learning: knowing their own limitations; enabling the student to develop their own practice and self-awareness by stepping in or stepping back; developing alliances with staff at the health care facility; acknowledging that the learning experience is reciprocal in nature; and identifying the appropriate clinical care buddies for students.

Brown's study (2006) sought to describe and understand the lived experiences of teaching for lecturer practitioners in the clinical workplace using a qualitative phenomenological approach. Five lecturer practitioners were asked to describe in their own words what it was like being a LP and working in the clinical area, and their responses were then recorded and transcribed. She found that LPs reported looking and seeing practice differently, and challenged practitioners to do the same, and that they worked in the middle of the practice theory gap, rather than trying to reduce it. By working in partnership with practitioners, the LPs were able to effect change in

the clinical environment whereby learning was supported and encouraged, by pushing the practitioner to develop their practice with the LPs working as educational enablers.

Another method undertaken was stakeholder evaluation (Hancock et al. 2007). In this study, each of five lecturer practitioners from a range of backgrounds, experience and practice, and their line manager identified six participants who were familiar with the LP's role. Semi-structured interviews were held with 36 participants, comprising students, registered nurses, doctors, managers and lecturers, but excluded service users, to obtain the perceptions of the stakeholder. Additionally, case studies were developed for each of the individual LPs to allow examination of similarities between roles and the roles specific to each LP. The role of LP emerged as diverse and multifaceted, and their role as a credible and valuable link between theory and practice, including university and clinical areas, was highlighted by all in the study. LPs were viewed as particularly valuable resources by junior and student nurses, but less so by more senior staff, who viewed them more in an advisory capacity. Concerns focused on the duality and scope of the role, which often generated conflicting demands, insufficient time in the clinical area and lack of continuity in each of the two roles.

An action research approach was used by Kelly & Simpson (2001) in order to facilitate the inception, development and subsequent evaluation of new clinical practice facilitator roles. Summary says important to consider the future potential of such posts, as educational providers may benefit from exploring closer links with those involved in facilitating the acquisition of nursing skills in NHS. These roles offer considerable potential within an educational system whereby more emphasis has been placed on academic achievement than mastering clinical nursing skills.

Fowler et al. (2007) evaluated an evidence-based framework for the development of joint appointments by reflecting on the lived experience. The team followed the framework developed by the Irish National Council for the Professional Development of Nursing and Midwifery (NCPDNM) (2005), and tested it empirically on a joint appointment between a university lecturer and a senior practice educator. The framework consisted of the following phases:

- Phase 1: articulate the vision
- Phase 2: actualise the vision
- Phase 3: ascertain the role
- Phase 4: action the role
- Phase 5: advance the role

The team found that the framework was valid compared to the lived experience of the joint appointment, and that the lived experience of the joint appointment was evaluated using the NCPDNM framework. All phases, with the exception of Phase Two, were considered to be highly valid, and the guidelines they contained could serve as a solid structure for new developments. Phase two, the planning phase, assumed a degree of

calculated planning, time, lack of conflicting priorities and seemed not to take the general activities of day-to-day life into consideration.

Conway and Elwin (2007) developed an example of a clinical nurse educator (CNE) performance management tool, using the Australian Nurse Federation Competency Standards for the Advanced Nurse as their basis. Whilst the CNEs indicated that they sought mechanisms with which to validate their practice, they were not supported by other stakeholders in terms of their professional development.

This overview of evaluation has highlighted the extent to which the available evidence focuses on a mixed method approach, often with a priority being given to educational impact. There are few evaluations that have measured explicitly the impact and contribution of nurses in these roles to improvements in practice, and none that have linked explicitly an assessment of role descriptions with impact or output..

Benefits and Challenges of Joint appointments

Joint appointments have been the subject of some focused research studies examining strengths and weaknesses of this type of model. .

Beitz & Heiner (2000) drew up a list of pros and cons associated with faculty joint appointments, including clinical, research and administrative:

Benefits:

- Increased salary base, self-esteem, and self-confidence
- Clinical practice based in reality and research grounded in clinical practice
- Opportunity to use APN skills (leadership, research, teaching, product evaluation)
- Positive feedback from patients, peers, and larger health care community
- Broadened opportunities for School of Nursing in the health care organisation
- Potential for cooperative publication and research
- Increased sensitisation to issues in practice and research
- Establishment of conduit for mutual educational influence between nursing staff and faculty
- Increased research use in contemporary practice
- Increased network of researchers, colleagues, and clinicians

Challenges:

- Physical and mental fatigue with competing worksite responsibilities
- Unanticipated increases in workload
- Potential resistance to innovative techniques/technology in the health care setting
- Conflict with academic responsibilities for promotion and tenure

- Difficulty in balancing professional and personal responsibilities
- Perception of difficulty in completing scholarship and publications

(Beitz & Heinzer 2000, p. 235) – **note possible copyright issues?**

Ogilvie et al. (2004) undertook a critical analysis of academic literature to look at the value and vulnerability of joint academic-clinical joint appointments, in conjunction with their own research and experience of four joint appointments in Alberta. Their findings corresponded closely to those of Beitz & Heiner. Some challenges in the UK reported by StLaR (Butterworth et al. 2004) were that nurse educators were often teaching more than their contractual hours and for longer than contractual weeks per year, pay differentials with service colleagues were cited as a barrier to recruitment and there was a reported leakage of academic staff to the service (p. 28).

One study found that if a practice educator role was allocated less than 0.5 wte, it was not effective or realistic (Jowett & McMullan 2007). Full-time versus part-time clinical faculty was also investigated by Kelly (2006). She found that full-time faculty demonstrated a relationship between their understanding of their role and their teaching activities, whereas part-time faculty members saw their clinical activities as focusing on current clinical practice, based on their own student experiences (see also Allison-Jones & Hirt 2004).

A study of nurse educators in Malta (Griscti et al. 2005) found that they allotted minimal time to their clinical role, with the main reasons given as workload, perceived lack of control over the clinical area, and diminished clinical competence. The overall view of the role of these staff was to prepare students for successful completion of their programme, rather than preparing them with all the clinical skills and knowledge necessary to be competent practitioners. It was also felt that they did not make opportunities to forge links with professional staff.

7. Career Pathways

One key area of examination for the review was to examine evidence on the career pathways that had been identified and implemented for nurses in these types of role. However, given the diversity in title, remit and location of learning support roles in the literature, it is perhaps not surprising that career pathways have not been much described, let alone defined in the research literature. In part this is likely to be a reflection of the variety of localised career structures and pay systems in use in many devolved health systems, such as in the United States and Canada. A common theme that emerges from the literature (and from case studies reported in the next section) is that of differential treatment for staff primarily employed as health service workers, or as education sector workers.

In the UK, Leigh et al. (2002) found that in the north of England, Lecturer Practitioners (LPs) and joint appointees who had a contract with the University could progress to senior lecturer and beyond and follow an academic career. However, those holding a Trust contract had their career determined by their practice roles and responsibilities, and by the way the Trust foresaw the development of the role, in line with service requirements. Nurses whose roles and responsibilities were predominantly education, training, development and research did not have a pathway to follow. In a subsequent study, they found that the lack of a career structure was not helped by the recurrent concern regarding role ambiguity (Leigh et al. 2005).

The Lecturer Practitioner role is often perceived as a stepping stone to a lecturer post, with no career structure for the LP except to choose either a clinical or an academic path. One study found that LP participants were concerned about lack of job security and were considering an alternative future career (Carson & Carnwell 2004).

Nurse educators in the UK are reportedly concerned about the lack of transferability between practice and higher education and wish to see more opportunities for clinical academic pathway development. (Butterworth et al. 2004, p. 28). A subsequent report by Butterworth et al. (2005) discussed the work of the StLaR project (www.stlarhr.org.uk) which focused on issues facing researchers and educators in nursing, health and social care. They developed three flexible career pathways. The first supports the younger, talented clinical academic working towards a joint consultant/professorial post, the second shows a route for a consultant practitioner and the third supports nursing into a training role within further education. Further development of this model would be to include the clinical nurse educator role, so that clinical career and academic career are integrated and practice education is the central focus (Pollard et al. 2006). (see also work carried out on career pathway development for nurses by Kenkre and Foxcroft (University of Glamorgan/Oxford Brookes University).

In the US, Beitz & Heiner (2001) talked about three formats for career pathways; clinical, research or administrative. Clinical nurse educators and their utilisation of, access to and support in the conduct of research has been investigated by several authors (Milner et al. 2005, 2006; Butterworth et al. 2005). Milner et al. (2006) found a positive relationship between research utilisation and attitude toward research, higher levels of education, and reading professional nursing journals among clinical nurse educators. The authors suggested that not all clinical nurse educators have the necessary critical appraisal skills and research knowledge to use research effectively in practice.

Also in the US, there has been long term local use of “clinical ladders” in nursing. Based on the work “From Novice to expert” by Benner (1992), these are organisation specific career structures, some of which explicitly include a education /mentoring /research career track, where career development on this track is systematically supported, criteria for advancement are transparent, and advancement is recognised in pay terms (see e.g Dracup K Bryan-Brown, 2004; Petterson, 2004)

Mallik & McGowan (2007) made several recommendations in light of their multi-professional scoping exercise in the UK and the Republic of Ireland, including:

- Employers should acknowledge and reward the demands of a practice education role in relation to clinical workloads
- A standard developmental model of practice education should be introduced that clarifies a practice education career pathway, e.g. associate mentor to mentor to practice educator
- Standardisation and evaluation of preparation programmes at appropriate levels to suit an interprofessional practice education career framework
- Clarification of practice education responsibilities for HEIs and placement providers

To achieve good practice, it is essential to reward and motivate nurse educators, and as Butterworth (2002) states, “offering career structures that will encourage people to stay as expert clinicians while providing them opportunities for research and applauding good teaching and research are the foundation stones of a strong clinical academic career” (p. 50). The same author has noted that recruitment and retention of staff in nurse education is compounded by the age profile of existing staff, with an estimated one in three aged 50 years or over (Butterworth et al. 2004).

Any examination of roles and rewards for staff working across the practice/education sectors in the NHS in the UK will have to take account of the impact of national policies on role descriptions and on pay structures. In particular, the current policy approach to ‘Modernising nursing careers’ (Scottish Executive (2006) acknowledges the need to progress increased career flexibility and overcome the clinical/academic role divide; whilst the new job evaluation based pay system for NHS staff (Agenda for Change”) and associated Knowledge and Skills Framework play a central role in determining the roles and rewards for these staff. Recent evaluation of the implementation of Agenda for Change in England (Buchan and Evans 2007) and in Wales (Jenkins 2007) have suggested that there have been regionalised/localised variation in implementation which may have led to related variations in pay rates for staff doing similar jobs.

8. Canada / New Zealand case study

To provide additional information on roles and contracts, case study information was obtained from Canada and New Zealand. In these two countries, there exist several models of employment for clinical education. These include clinical education provided by full time or part time faculty, sessional clinical instructors, and joint appointments. Each of these is shaped by and has evolved as a result of a number of factors, and each of these models also has its own advantages and disadvantages. In New Zealand, although most health care is delivered in the public sector, reform led decentralization of the health sector in the 1990's led to local variation in approach, underpinned by local, and varying pay contracts (now being reversed to national level pay bargaining for nurses). In Canada, the federated system and a mixed economy of health care providers has also led to variations at local level.

The following section will describe each of the main models.

Full-time or Part-time Faculty

In Canada, many full time and part time professors and associate professors undertake responsibility for clinical education in addition to their provision of classroom based theory. However this has become increasingly difficult over the years due to a number of factors often leading to a reduction in the number of faculty who engage in such activity. First, the shortage of qualified nursing faculty in Canada has forced post doctoral, PhD and Master's prepared faculty to concentrate their efforts on developing and delivering a strong theoretical nursing foundation. Second, for those faculty who are tenure or seeking tenure or who are involved in academic upgrading, research is their focus. The post secondary education system in Canada places great emphasis on the generation of new knowledge in the form of research and publication. Many faculty report that clinical education is the least valued aspect of education. There are almost 2 parallel tracks within education-academia and clinical-and rare the two shall cross paths. As result, many faculty have chosen to forgo the clinical education aspect of their position to further their academic role, prestige and position within the education system. Third, is the changing model of clinical education. Many clinical placements are now being offered in rural settings, sometimes across provincial/territorial boundaries. The impetus for this is twofold: to improve access to nursing education in Canada for those living in rural and remote settings and to address the shortage of clinical placements in Canada. This distributive model of education limits the role the faculty can play in clinical education due to sheer geography. It forces schools of nursing to increasingly rely on sessional clinical instructors physically located in rural and remote settings.

Sessional Clinical Instructors

This is a model noted in particular in Canada. For many of the reasons noted in the section above (qualified faculty shortage, focus on research and distributive models of nursing education), the schools of nursing in Canada have come to rely largely on sessional clinical instructors to augment their faculty involved in delivering clinical education. These clinical instructors are nurses employed by health care service facilities. Often, these nurses are employed full time or part time in the delivery of health services and have separate contracts with academic institutions for a specified term to provide clinical education. The clinical instruction they provide may or may not be co-located at their health service facility. If the nurse is employed part time in health service delivery they may also teach or co-teach a class and provide clinical instruction. Occasionally, they may be seconded by the academic institution from their health service role in which case their salary is paid by the academic institution. One of the major benefits of using clinicians to provide clinical education is their clinical expertise. The health care environment is ever changing and evolving with new procedures, technology and pharmaceuticals emerging every day. Keeping current in this field is a challenge, one that is best met through the use of those who practice in it every day. However, this model faces several challenges. First, according to Statistics Canada, nursing faculty are the lowest paid of the health professions. Nurses earn a higher salary in their unionized health service delivery role than they do in their position with the academic institution. There is no monetary incentive for them to provide clinical education. Second, while these nurses are often expert clinicians, they have minimal pedagogical preparation. Academic institutions often provide little or no pedagogical instruction for their new clinical instructors. And for those that do, this instruction is constantly being provided due to the frequent turnover of clinical instructors.

Several organizations and collaborations are attempting to address the minimal pedagogical preparation. In Canada, McGill University has collaborated with its practice network of clinical instructors to develop academic practice workshops. These workshops focus on building the nurses' clinical education capacity. It supports their development of pedagogical expertise so that they may fulfill their roles of teaching and evidence based practice.

Also in Canada, the British Columbia government, 2 regional health employers and 2 universities in British Columbia, Canada have collaborated to develop and implement a three year pilot project to build nursing educator capacity in health authorities and schools of nursing. The primary objective of this collaboration is to demonstrate an innovative approach to workplace skill development by creating an integrated intersectoral service and education model. Based on an educator competency framework, the collaboration has developed a graduated educator pathway which ultimately results in a Master's of Nursing, with a particular focus on education. The program is comprised of course courses such as ethics and several nurse educator courses. The specific intentions and supports of the final step, being the MSN, include:

- Participants (employed full or part time) are able to complete program in 2 years
- Organizations support 50 % tuition and up to 20 paid educational days per year
- University Programs will consider adapting or adding flexible delivery methods
- Opportunities will be provided for participants to apply what they are learning to their current practice
- Organization will have frequent contact with participants to explore challenges and provide support

Joint Appointments

Joint appointments have been in existence for many in both Canada and New Zealand. In this model, nurses are employed by a health service facility and provide an agreed number of days of clinical instruction for an academic institution. A formal collaboration exists between the university and health service facility. Feedback from respondents in both countries suggests that the salary provided to the nurse often remains the responsibility of the health service institution.

In many cases the clinical instruction is provided in the same facility in which the nurses provides health services in his/her other role. This is regarded as being one of the benefits to the health service institution. They are able to promote the adequate preparation of new graduates for their particular focus of practice, whether it be public health or acute care. It is reportedly a model that has proven quite popular with public health units in Canada. It is also a model that promotes recruitment of new graduates by exposing students to their facility. The nurses often engage in joint appointments not only for the opportunity to teach, but also to have their name affiliated with a prestigious academic institution. Another benefit to the health service facility is access to academic scholarship and infrastructure- assistance with research and other scholarly activities. Unfortunately, key informants in both countries indicate this does not always come to fruition. Often the collaboration benefits the academic institution more so than the health service facility.

Respondents note that the challenges of this model for the nurse include role strain from split responsibilities, blurring of roles and responsibilities, potential for over-commitment and complex time management- reports echoed by the literature in this area..

Honorary appointments exist in both countries, but as one New Zealand respondent noted: "Honorary roles are just that, and privileges are worked out on a case by case basis".

In New Zealand a range of models are in use. One District Health Board (DHB) reported that it followed the following principles in joint appointments:

- One employer, Position Description (PD) and one nominated line manager
- Professional reporting line to the other partner (DHB or Education)
- Shared development of annual performance objectives and appraisal
- Dual belonging ie. Recognition as staff member on both sides
- Shared cost of salary and staff related expenses – “we invoice each other for the agreed amounts monthly”
- Alignment with collective employment agreements

For “buy- back” roles, ie nurse educators or similar, it is agreed how many FTE/ number of days are required and an invoice goes to the University for the nurse’s time based on current salary rates, etc. .

A second NZ DHB reported that it had a joint appointment staff member with the local school of nursing, but this post was considered to be a DHB employee and is paid on national rates “ not on education pay rates which are less”.

Another NZ DHB reported that Clinical Nurse Educators were employed in most of their services, and were established health service posts paid on health sector agreed rates, whilst the local polytechnic employed Student Nurse educators to support their students on placement, under education sector pay rates (which are reportedly lower).. A fourth DHB reported that a different model for the positions that were shared between the DHB and the education provider - in that individual staff, up to and including the director of nursing are "seconded" and whichever organisation is the substantive employer invoices the organisation to which the individual is seconded e.g for the director of nursing role, the DHB pays health sector pay and conditions of employment to the post holder but the education sector organization reimburses the DHB an agreed rate for 0.3 days per week time- the agreed time that the Director contributes to relevant educational issues.

9. Conclusion

This review has examined the published evidence relating to roles of nurses that ‘bridge’ practice and education: areas explored in the review included models of employment, career structure, and role content of nurses in these roles. A typology of different organisational level models of clinical-academic collaboration was provided.

In practice the review of published material highlighted that there is very little published information on the employment/contractual/role description aspects of the use of nurses in these roles. Most of the published literature is from the academic/educationalist perspective- it usually describes different models of joint appointment or education/ practice, but does not provide much information (if any) about role descriptions, and employment contractual matters. There are also few examples of evaluation that focus beyond the effect of the type of model on student/ staff experience or on measures of

educational impact. In practice, a range of contractual models were identified- with joint appointments being most common- but the actual nature of the contract in this model varying between countries and systems.

In examining the role and contractual situation of PEF in NHS Scotland, the impact of Agenda for Change is a central determinant; both in relation to pay determination under this system, and more broadly, there is a case to be made for consistency in application of role descriptions and contracts. In this regard, the Memorandum of Understanding outlined by NHS Employers in England has some useful pointers (NHS Employers 2007). This MOU aims to set out the NHS and University understanding of the role of joint staff of NHS organisations and Universities who are engaged in both teaching and/or research as well as in the delivery of patient care. The objective of the MOU is to clarify selected duties and responsibilities of their employers. Whilst aimed primarily at doctors and dentists “The document therefore deliberately encompasses any health care professional engaged in both teaching and/or research as well as the delivery of patient care”. The MOU makes recommendations on employment contracts and on remuneration.

What does emerge from the review is clear evidence that nurses working in the practice/ education area can be subject to role conflict, that other health systems (eg Canada and New Zealand) report a multiplicity of contract approaches (reflecting the devolved nature of these health systems) , and that nurses working across the two sectors may be at a contractual disadvantage if they are primarily contracted by one sector which has less attractive terms and conditions of employment, whilst working across both sectors. Related to the last point, there are few examples of integrated career structures that can accommodate these roles effectively- some local level clinical ladders in the US may be exceptions, but in general staff occupying these roles in different countries do not usually have a clear career path- at some point they may have to decide to opt in either to education or service as the career route. The challenge for policy makers and managers is to develop clear and transparent contracts and role/job descriptions which can minimise role overlap or conflict, can fairly reward staff in relation to their peers, and can recognise staff for their contribution and encourage career aspirations.

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